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Behavioral Health is Essential To Health

Prevention Works

Treatment is Effective

People Recover

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Trends in Behavioral Health

SAMHSA PBHCI National Grantee Meeting
June 4- 7, 2017 • Austin, TX

Disclaimer

The views, opinions, and content expressed in this presentation do not necessarily reflect the views, opinions, or policies of the Center for Mental Health Services (CMHS), the Substance Abuse and Mental Health Services Administration (SAMHSA), the Health Resources and Services Administration (HRSA), or the U.S. Department of Health and Human Services (HHS).

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My Background

- **Medical Director for National Council for Behavioral Health**
- **Practicing Psychiatrist in a Community Health Center**
- **Distinguished Professor, Missouri Institute of Mental Health, University of Missouri St. Louis**
- **Previously**
  - *Medicaid Director for Missouri*
  - *Medical Director Missouri Department of Mental Health*

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2000 Up to 2008

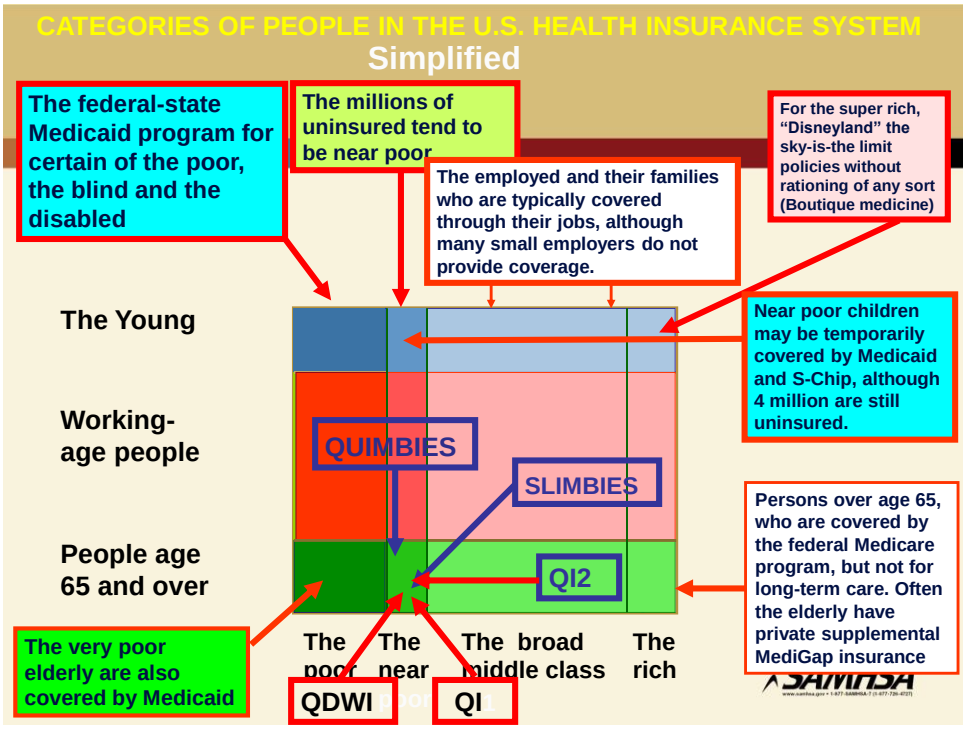
- **Bed capacity fairly stable**
- **Reduce discrimination**
- **Increased medication usage**
- **Increased MH prescribing by PCPs**
- **Emergence of EBP**
- **Integration of BH and medical care**

"Better But Not Well" Richard Frank, PhD

- **Improvements in Care to MI due to:**
  - *Disabled income and housing supports*
  - *Newer medications easier to prescribe correctly*
  - *Many more persons with SMI treated by PCPs with medication*

Overall

- Treatments get continually better
- Community focus and locus increases
- Financing and administration has become ridiculously complex



Alexis Pozen
David M. Cutler

Medical Spending Differences in the United States and Canada: The Role of Prices, Procedures, and Administrative Expenses

The United States far outspends Canada on health care, but the sources of additional spending are unclear. We evaluated the importance of incomes, administration, and medical interventions in this difference. Pooling various sources, we calculated medical personnel incomes, administrative expenses, and procedure volume and intensity for the United States and Canada. We found that Canada spent $1,589 per capita less on physicians and hospitals in 2002. Administration accounted for the largest share of this difference (39%), followed by incomes (31%), and more intensive provision of medical services (14%). Whether this additional spending is wasteful or warranted is unknown.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3024588/

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2008 through 2010
Suddenly A New Environment

- **2008 – MH and SA Parity Act**
- **2009 – Economic Crisis**
- **2009 – HIT Act**
- **2010 – Health Care Reform**

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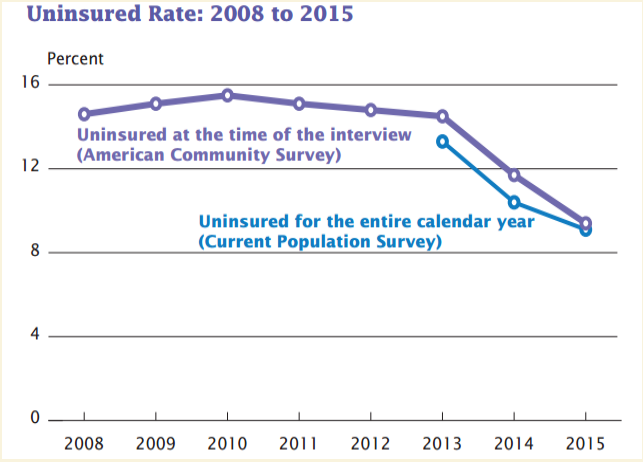
More Americans Gaining Coverage (that includes Parity)



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Yet, lack of access, disparities persist…

- Mental illness is the leading source of disease burden in the US
- Addiction has become a public health crisis
- Suicide rates are climbing
- Continued high levels of unmet need for care
- Little access to care even among working people with health coverage
- Lack of access to care has a critical impact on special populations: children, people of color, justice-involved

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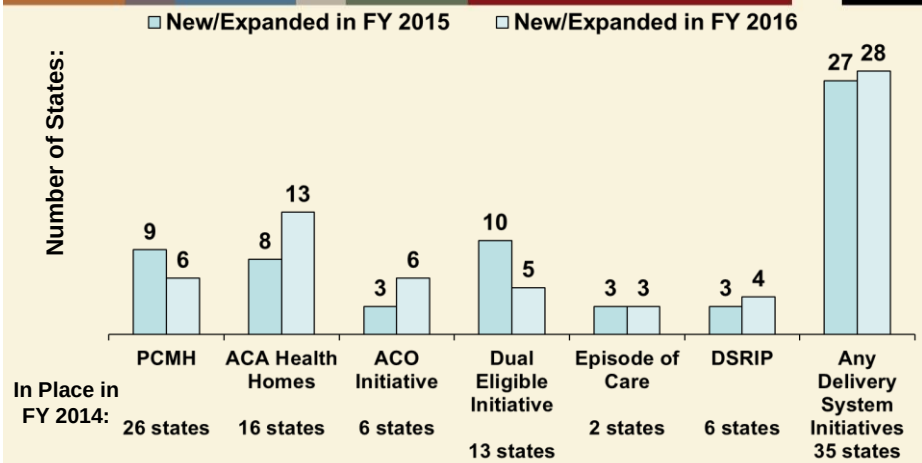
State Delivery System Reform Initiatives
FY 2015 and FY2016



NOTE: Expansions of existing initiatives include rollouts of existing initiatives to new areas or groups and significant increases in enrollment or providers.
SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2015.

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CCBHC States

- Minnesota
- Missouri
- New Jersey
- Nevada
- New York
- Oklahoma
- Oregon
- Pennsylvania

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Delivery System Redesign

- **Data Driven Care**
  - *Care Management*
  - *Care Coordination*
- **Population Management**
- **Integration of Behavioral Healthcare and General Healthcare**
- **Increase Use of Preventive care**
- **Increase Access to Primary care**
- **Health Information Technology Interoperability STDS**

Payment Reforms

- **Bundled Payments**
- **Global Payments**
- **Pay for Performance**
- **Accountable Care Organizations (ACOs)**
- **Reduces Hospital Payments**
- **Increases Primary Care and Preventive care Payments**

Where are we today? The Good News

- **There is growing awareness of our issues**
  - *Understanding that behavioral health is essential to whole health*
  - *Sustained media attention, growing numbers of people talking openly about their or their loved one's experience*
- **More Americans have coverage than ever before**
  - *Coverage includes parity for most Americans*
  - *Full parity implementation has proven difficult, many consumers still lack access to key services*

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Good News: Growing recognition that…

- **Behavioral health is essential to whole health**
  - *Higher costs, poorer overall outcomes associated with co-occurring BH and physical health conditions*
- **Treatment works**
- **Recovery and a fully functioning life in the community are possible**

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Public Attention to Mental Health and Addiction is Growing

The New York Times

"Elsewhere, groups or networks have formed to spread the knowledge…They include the National Council on Behavioral Health's Trauma-Informed Care Learning Community…"

The Washington Post

Trying to make mental health first aid as familiar as CPR

C-SPAN

npr

Shortage Of Addiction Counselors Further Strained By Opioid Epidemic

CNBC

Can treating past trauma lead to big US health savings?

Dan Mangan | @_DanMangan
Thursday, 21 Jan 2016 | 2:00 PM ET
CNBC

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19

Fact: Addictions – Public Health Crisis

Addictions as chronic diseases ... medications … inpatient … residential and outpatient treatments … and recovery supports including **housing**

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Rising morbidity and mortality in midlife among white non-Hispanic Americans in the 21st century

Anne Case[1] and Angus Deaton[1]

Woodrow Wilson School of Public and International Affairs and Department of Economics, Princeton University, Princeton, NJ 08544

Contributed by Angus Deaton, September 17, 2015 (sent for review August 22, 2015; reviewed by David Cutler, Jon Skinner, and David Weir)

This paper documents a marked increase in the all-cause mortality of middle-aged white non-Hispanic men and women in the United States between 1999 and 2013. This change reversed decades of progress in mortality and was unique to the United States; no other rich country saw a similar turnaround. The midlife mortality reversal was confined to white non-Hispanics; black non-Hispanics and Hispanics at midlife, and those aged 65 and above in every racial and ethnic group, continued to see mortality rates fall. This increase for whites was largely accounted for by increasing death rates from drug and alcohol poisonings, suicide, and chronic liver diseases and cirrhosis. Although all

the United Kingdom (UK), Canada (CAN), Australia (AUS), and Sweden (SWE). The comparison is similar for other Organisation for Economic Co-operation and Development countries.

Fig. 1 shows a cessation and reversal of the decline in midlife mortality for US white non-Hispanics after 1998. From 1978 to 1998, the mortality rate for US whites aged 45–54 fell by 2% per year on average, which matched the average rate of decline in the six countries shown, and the average over all other industrialized countries. After 1998, other rich countries' mortality rates continued to decline by 2% a year. In contrast, US white non-Hispanic mortality rose by

SOURCE: *Proceedings of the National Academy of Sciences*, vol. 112 no. 49: 15078–15083
http://www.pnas.org/content/112/49/15078.full

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Mortality by Cause, White non-Hispanics

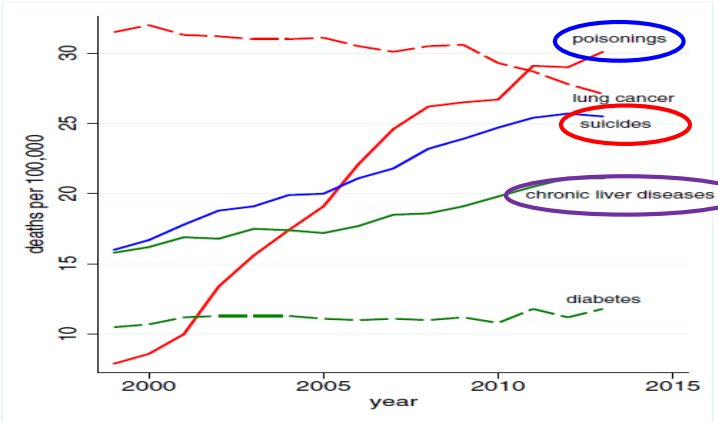

Fig. 2. Mortality by cause, white non-Hispanics ages 45–54.

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Mortality by Poising, Suicide, Chronic Liver Disease and Cirrhosis

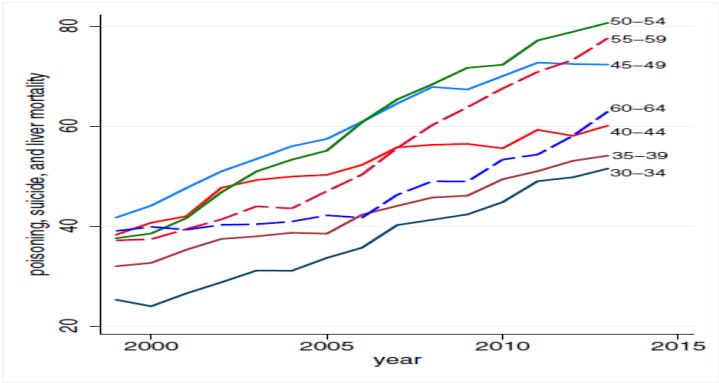
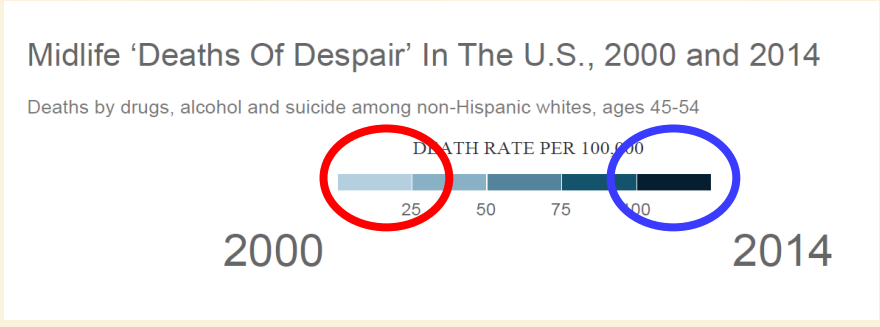


Fig. 4. Mortality by poisoning, suicide, chronic liver disease, and cirrhosis, white non-Hispanics by 5-y age group.

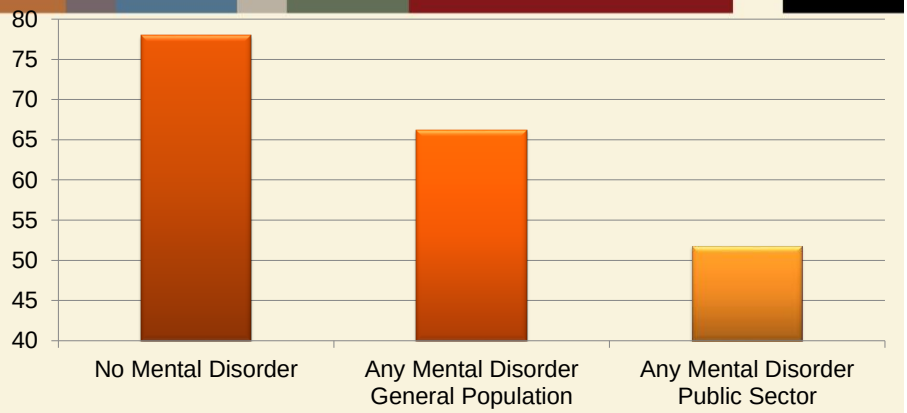
SOURCE: Angus Deaton and Anne Case, "Rising morbidity and mortality in mid-life among white non-Hispanic Americans in the 21st century," http://www.pnas.org/content/112/49/15078.full

"Deaths of Despair" Among Middle-Class Whites



SOURCE: Jessica Browdy, "The Forces Driving Middle-Aged White People's 'Deaths of Despair'". Health news from NPR. March 23, 2017. http://www.npr.org/sections/health-shots/2017/03/23/521083335/the-forces-driving-middle-aged-white-peoples-deaths-of-despair citing Brookings paper by Angus Deaton and Anne Case https://www.brookings.edu/bpea-articles/mortality-and-morbidity-in-the-21st-century/

Life Expectancy



Bar 1 & 2: Druss BG, Zhao L, Von Esenwein S, Morrato EH, Marcus SC. Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. Med Care. 2011 June;49(6):599-604

Bar 3; Daumit GL, Anthony CB, Ford DE, Fahey M, Skinner EA, Lehman AF, Hwang W, Steinwachs DM. Pattern of mortality in a sample of Maryland residents with severe mental illness. Psychiatry Res. 2010 Apr 30;176(2-3):242-5

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Comparison of Metabolic Syndrome Prevalence in Fasting CATIE Subjects and Matched NHANES III Subjects

	Males			Females		
	CATIE N=509	NHANES N=509	*p*	CATIE N=180	NHANES N=180	*p*
Metabolic Syndrome Prevalence	36.0%	19.7%	.0001	51.6%	25.1%	.0001
Waist Circumference Criterion	35.5%	24.8%	.0001	76.3%	57.0%	.0001
Triglyceride Criterion	50.7%	32.1%	.0001	42.3%	19.6%	.0001
HDL Criterion	48.9%	31.9%	.0001	63.3%	36.3%	.0001
BP Criterion	47.2%	31.1%	.0001	46.9%	26.8%	.0001
Glucose Criterion	14.1%	14.2%	.9635	21.7%	11.2%	.0075

Meyer et al., Presented at APA annual meeting, May 21-26, 2005.
McEvoy JP et al. Schizophr Res. 2005;80:19-32.

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The CATIE Study

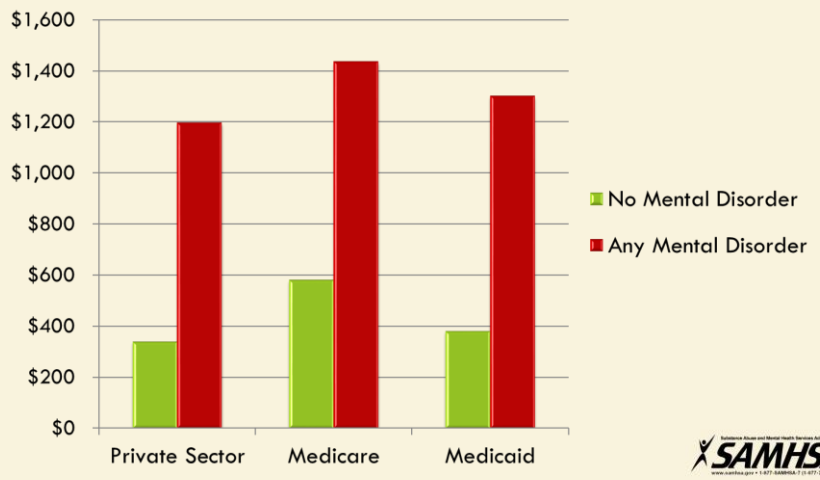
At baseline investigators found that:

- *88.0% of subjects who had dyslipidemia*
- *62.4% of subjects who had hypertension*
- *30.2% of subjects who had diabetes were NOT receiving treatment*

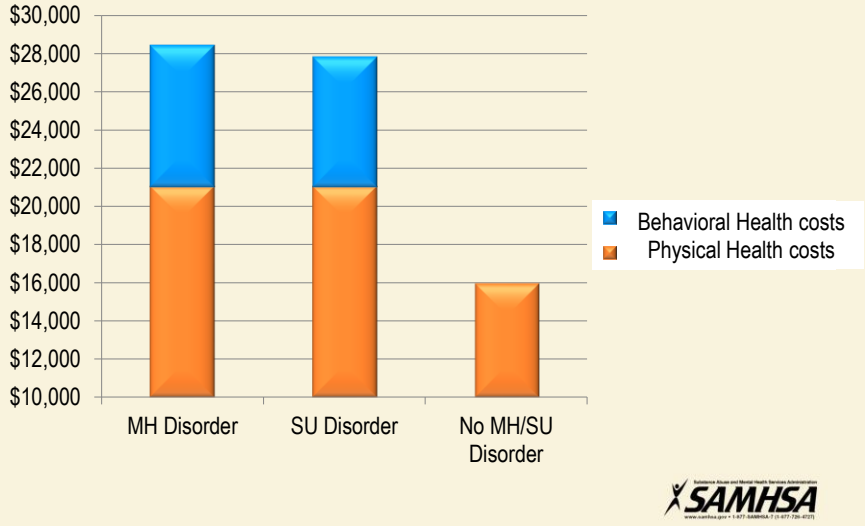
Causes of Excess Mortality

- **Smoking**
- **Obesity**
- **Inactivity**
- **Polypharmacy**
- **Under diagnosis of medical conditions**
- **Inadequate treatment of medical conditions**

Per Member Per Month Costs

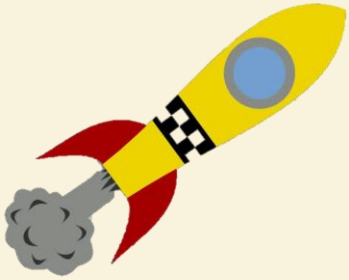


MH/SU costs in NY State's Medicaid Program



Rocket Science

DOES THE BROADER HEALTHCARE INDUSTRY NEED BEHAVIORAL HEALTH TO SUCEED?



Drivers of Increased Demand for Behavioral Health Care

- **Insurance reform substantially increases behavioral health coverage for adults**
- **Insurance reform requires newly covered populations meet the parity requirements of Wellstone Domenici Parity Act**
- **Reform requires or incentivizes integration of Behavioral Health and general medical care**
- **Stigma continues to drop releasing pent up demand**
- **Press coverage and mental health impact**

New Drivers of BH Demand

- **Medicaid Access Rule**
  - *Went into effect October 2016*
  - *Requires that MHD monitor and report on Access to 5 essential provider types – one is BH*
- **Medicaid Managed Care Rule**
  - *Extends Wellstone-Domenici BH Parity to Medicaid Managed Care*
  - *Requires very detailed parity analysis for every eligibility group/benefit plan – approx. 100 in MO!*
- **Medicare MACRA P4P**

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Fact: Working people have little access to care

- Escalating deductibles/copays make treatment for mental illness (OCD, anxiety, depression - conditions highly responsive to medication and cognitive interventions) out of reach.
- Equally destructive are stagnant insurance reimbursement rates that make behavioral health cash only businesses.

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Medicaid is Largely a BH Funding Program

- **Single largest payer for BH services accounting for 26% of all behavioral health spending in 2009**
- **The 20% of Medicaid beneficiaries with a BH diagnosis account for 48% of all Medicaid expenditures**
- **Total Average Medicaid Expenditures**
  - *With BH diagnosis $13,303*
  - *Without BH diagnosis $3564*
- **About half of the non-dually eligible, under age 65 (including children) with disability have a behavioral health diagnosis**
- **Total Medicaid expenditures for this group accounts for two thirds of total Medicaid spending**

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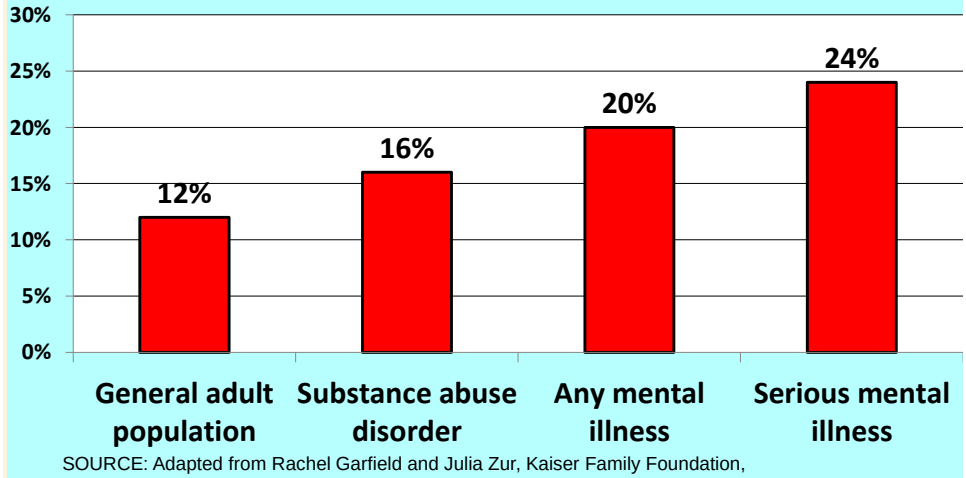
Percent of Adult Group Covered by Medicaid, 2014



SOURCE: Adapted from Rachel Garfield and Julia Zur, Kaiser Family Foundation, http://kff.org/medicaid/issue-brief/medicaid-restructuring-under-the-american-health-care-act-and-implications-for-behavioral-health-care-in-the-us/

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Medicaid is Radically Different from Commercial or Medicare Coverage

- **Targets high need populations left out of other insurance programs**
- **Negligible co-pays and no deductibles**
- **Coverage available nowhere else**
  - *Long term services and supports – NH, Personal care, Home health*
  - *Specialized support programs for specialized populations – SMI, DD, Foster care children, HIV,*
  - *Transportation to and from treatment*
- **Innovation**

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Innovative Medicaid Programs For Behavioral Health Populations

- **Community support services and case management**
- **Crisis services and hotlines**
- **ACT teams**
- **Peer services**
- **ER diversion programs**
- **Partial hospital**
- **Residential treatment**
- **Psychosocial rehabilitation**
- **CMHC health homes**
- **Family support**

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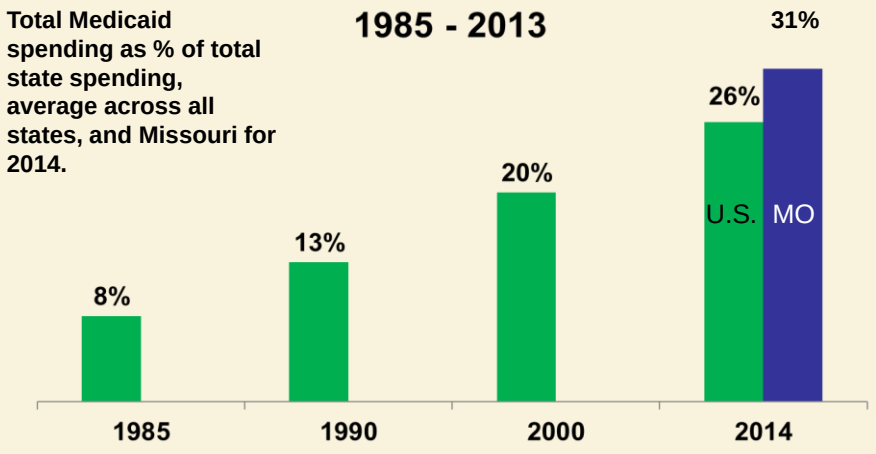
Medicaid Spending Now Averages 26% of Total State Budgets

Total Medicaid spending as % of total state spending, average across all states, and Missouri for 2014.



Source: HMA, based on NASBO, *State Expenditure Report*, 2014 and earlier years.

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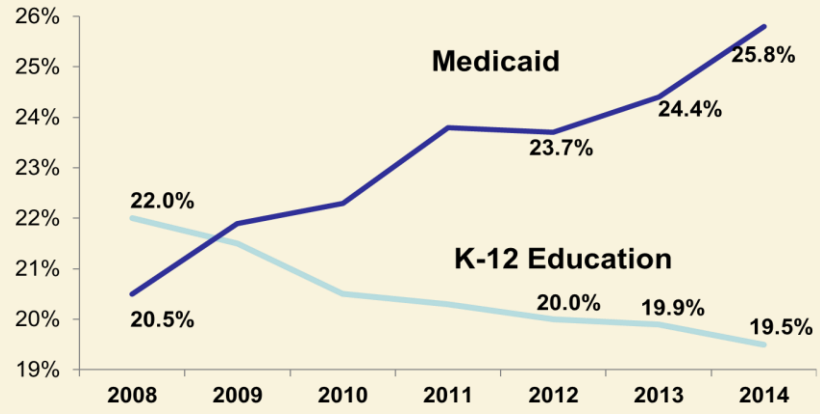
Total Spending on Medicaid and K–12 Education as % of Total State Spending

Average State Percentages, 2008 – 2014



Source: HMA, based on data in: NASBO, *State Expenditure Report*, 2014 and Earlier Years.

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Big Trends

- **Increased coverage**
- **Increased demand**
- **Focus of high utilizers**
- **Increased desire for integration by payers**
- **Provider consolidation**
- **Performance based payments**
- **Shrinking psychiatric workforce**

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HRSA Projects Ongoing Shortages of Professionals

By 2025…

- **If levels of demand remain constant, shortages projected among 5 key behavioral health provider types**
- **If levels of demand increase, shortages projected among 9 key provider types**
  - *Including shortages of **more than 10,000 FTEs** among psychiatrists, psychologists, social workers, SUD counselors, mental health counselors, & school counselors*

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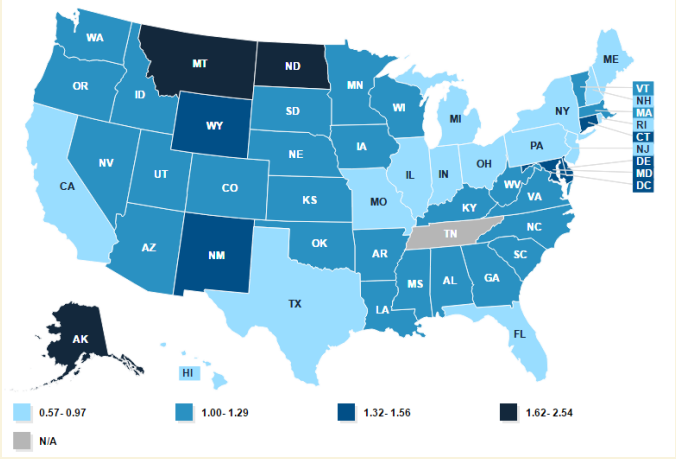
Ability to recruit & retain staff limited by low rates



Map shows ratio of Medicaid to Medicare payment rates

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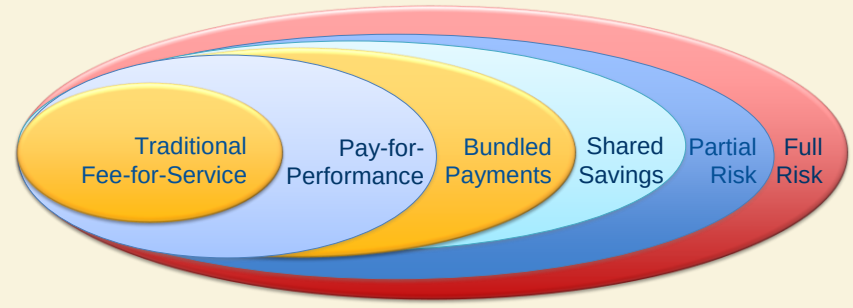
Payment reform shifts risk & accountability to providers



Episodic Cost Accountability — *Total Cost Accountability*

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Moving from episodic "sick care" to population health management

In 2010, there were no ACOs…

Today, there are more than **700.**

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Focus: Measurement Based Care

If you don't measure it, you can't improve it

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Data Sources

- **Claims – broad but not deep, already aggregated**
  - *Diagnosis*
  - *Procedures including Hospital and ER*
  - *Medications*
  - *Costs*
- **EMR Data Extracts – deep but not broad, need aggregating**
- **Practice Reported – administrative burden**
  - *Metabolic Values – Ht, Wt, BP, HbA1c, LDL, HDC*
  - *Satisfaction and community function – MHSIP*
  - *Staffing and Practice Improvement*
- **Hospital Stay Authorization – hospital admissions**

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Data You Need to Manage

- **Aggregate reporting – performance benchmarking**
- **Individual drill down – care coordination**
- **Disease registry – care management**
  - *Identify Care Gaps*
  - *Generate to-do lists for action*
- **Enrollment registry – deploying data and payments**
- **Understanding – planning and operations**
- **Telling your story – presentation like this**

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Principles

- **Use the data you have before collecting more**
- **Show as much data as you can to as many partners as you can as often as you can**
  - *Sunshine improves data quality*
  - *They may use it to make better decisions*
  - *It's better to debate data than speculative anecdotes*
- **When showing data ask partners what they think it means**
- **Treat all criticisms that results are inaccurate or mis-leading as testable hypotheses**

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More Principles

- **Tell your data people that you want the quick easy data runs first. Getting 80% of your request in 1 week is better than 100% in 6 weeks**
- **Treat all data runs as initial rough results**
- **Important questions should use more than one analytic approach**
- **Several medium data analytic vendors/sources is better than on big one**
- **Transparent bench marking improves attention and increases involvement**

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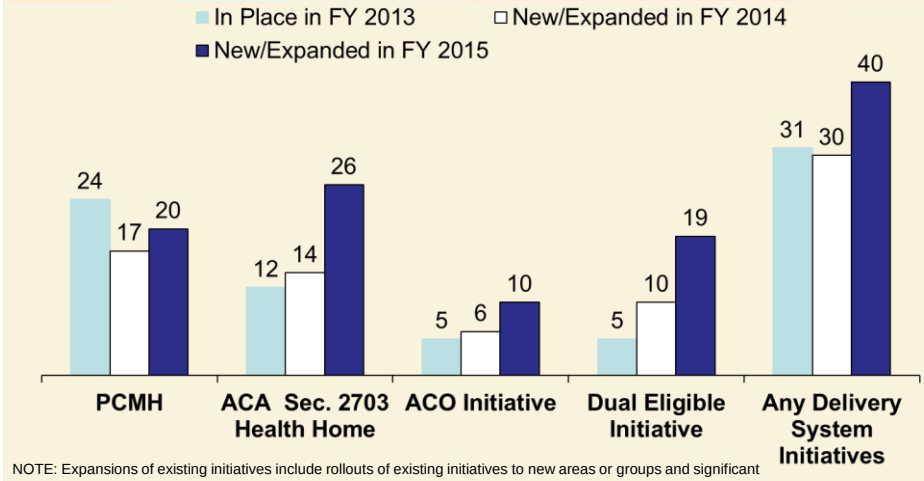
Most Important Principles

- Perfect is the enemy of good
- Use an incremental strategy
- If you try figure out a comprehensive plan first you will never get started
- Apologizing for a failed prompt attempt is better than is better than apologizing for missed opportunity

Delivery System Reforms to Coordinate Care and Control Costs Are in Most States in 2014 - 2015



NOTE: Expansions of existing initiatives include rollouts of existing initiatives to new areas or groups and significant increases in enrollment or providers. Dual Eligible Initiatives include those through and outside CMS financial alignment demonstration.
SOURCE: Vernon Smith, et al., "Medicaid in an Era of Health & Delivery System Reform: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2014 and 2015," Kaiser Family Foundation, October 2014.

Prospective Payment History

- **Medicare Payments**
  - *Hospital since 1985 – previously were reimbursed for "Allowable Costs"*
  - *FQHCs since 2013*
- **Medicaid Payments**
  - *FQHCs since 2000 – previously were reimbursed based on annual cost report*

Prospective Payment Systems

- **Single payment for a specific period of time or episode of care for a service bundle at the projected average cost of that service bundle**
- **FQHC Medicare – A single national rate ($158.85)set by CMS with adjustment for geographic cost and visit intensity (up 34% for initial and annual wellness)**
- **FQHC Medicaid – States specific methodology within CMS guidelines and final method approved by CMS**
  - *PPS only: 21 States*
  - *Alternative Payment Method (APM):12 States*
  - *Both:12 States*

Advantages of PPS

- **Compared to Fee for Service**
  - *Fewer claims to submit or process and pay*
  - *Less incentive to do more services to generate more revenue*
  - *Results in less volatile and more predictable payments*
- **Compared to Cost Reimbursement**
  - *Less incentive to do increase costs to generate more revenue*
  - *Does not require annual cost report and re-setting rates*
  - *Does not require interim payments and end of year reconciliation calculation and payment*

PPS Opportunities

- **Able to include some costs not currently in FFS**
  - *Training*
  - *EHRs*
  - *Prevention services*
  - *None face – to- face time*
  - *Peer services*
  - *Employment supports*
  - *Cost of maintaining crisis system capacity*
- **Able to include quality bonus**

MACRA – What is it?

- **Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).**
- **MACRA, bipartisan legislation, replaces the flawed Sustainable Growth Rate formula by paying clinicians for the value and quality of care they provide**
- **The new "Quality Payment Program" has two paths:**
  - *The Merit-based Incentive Payment System (MIPS)*
  - *Advancing Alternative Payment Models*

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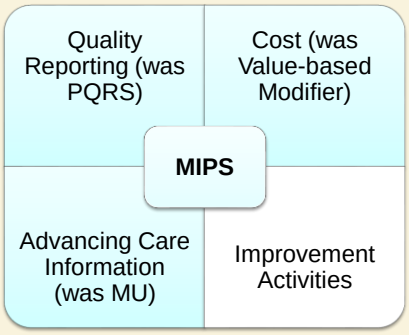
MIPS Components



MIPS aims:
- Align 3 current independent programs
- Add 4th component to promote improvement and innovation
- Provide more flexibility and choice of measures
- Retain a fee-for-service payment option

Clinicians exempt from MIPS:
- First year of Part B participation
- Medicare allowed charges ≤ $30K or ≤ 100 patients
- Non-patient facing with ≤ 100 patients
- Advanced APM participants

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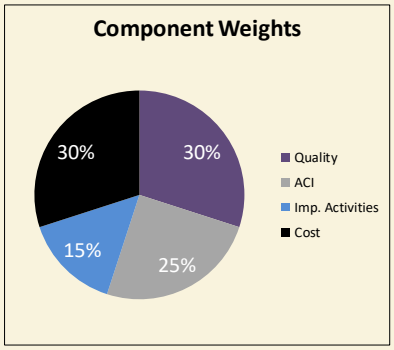
MIPS Component Weights (when fully transitioned)



For 2017:
- Quality = 60%
- ACI = 25%
- IA = 15%
- Cost = 0%

Component Scoring

- **Quality:**
  - *60 points groups ≤15*
  - *70 points for larger groups*
- **Advancing Care Information:**
  - *50 points base score*
  - *90 points performance score*
- **Improvement Activities:**
  - *40 points (2-4 activities; 1-2 activities for practices ≤ 15 clinicians and rural)*
- **Cost:**
  - *10 points per measure*
  - *Score is average of attributable measures*

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Merit Based Incentive Program

Who will NOT participate?

- **Providers in their FIRST year of Medicare Part B participation**
- **Providers with a low Medicare volume**
- **Medicare claims </= $10,000**
- **Provider care for </= 100 Medicare patients in one year**
- **Providers participating in advanced alternative payment models**

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Quality: What is the requirement?

- **Providers will choose 6 measures that are relevant to their practice**
  - *Must include one outcome measure or high value measure*
  - *Must include a cross-cutting measure*

OR

- **Providers can report a Specialty Measure Set**

Important Provider Competencies

Characteristics:

- **Outcomes-oriented**
- **Enabled by technology**
- **Patient-centered**
- **Use of data and analytics**
- **Performance transparency**
- **Ability to partner across organizations**

What BH Organizations Need to Evolve and Prosper

- **A Role no one else wants or can do**
- **Data, Data, and more Data**
- **Willingness to Change**
- **Willingness to Risk**
- **Integration with the Rest of Health Care**
- **Training, Training, and more Training**

Medicaid Reform Proposals Further Crunch States… and Providers

- **Proposals to reduce federal share of Medicaid put pressure on states**
- **Common cost-cutting actions by states include:**
  - *Provider pay cuts*
  - *Coverage rollbacks/limitations*
  - *Benefit reductions*

Repeal/Replace/Repair?

- **Off the Table for Now**
  - *The Market Place*
  - *Repeal of Medicaid Expansion*
- **Current Proposal**
  - *Essential Health Benefits*
  - *Pre-Existing Conditions/Community Rating*

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Problem Statement

Exhibit 7: Frequency of Diagnostic Dyads by Cost among Medicaid-only Beneficiaries with Disabilities, 2002, CDPS + Rx Data*

Diagnosis 1	Diagnosis 2	Frequency among all beneficiaries	Frequency among most expensive 5%
Psychiatric	Cardiovascular	24.5%	40.4%
Psychiatric	Central Nervous System	18.9%	39.8%
Cardiovascular	Pulmonary	12.5%	34.3%
Cardiovascular	Central Nervous System	13.1%	32.9%
Psychiatric	Pulmonary	11.2%	28.6%
Cardiovascular	Gastrointestinal	10.2%	27.8%
Central Nervous System	Pulmonary	7.0%	26.2%
Cardiovascular	Renal	7.1%	24.6%
Pulmonary	Gastrointestinal	5.9%	24.2%
Psychiatric	Gastrointestinal	9.5%	24.0%

The Faces of Medicaid III: Refining the Portrait of People with Multiple Chronic Conditions Center for Health Care Strategies, Inc., October 2009

- **49% of Medicaid beneficiaries with disabilities have a psychiatric illness.**
- **52% of those who have both Medicare and Medicaid have a psychiatric illness.**

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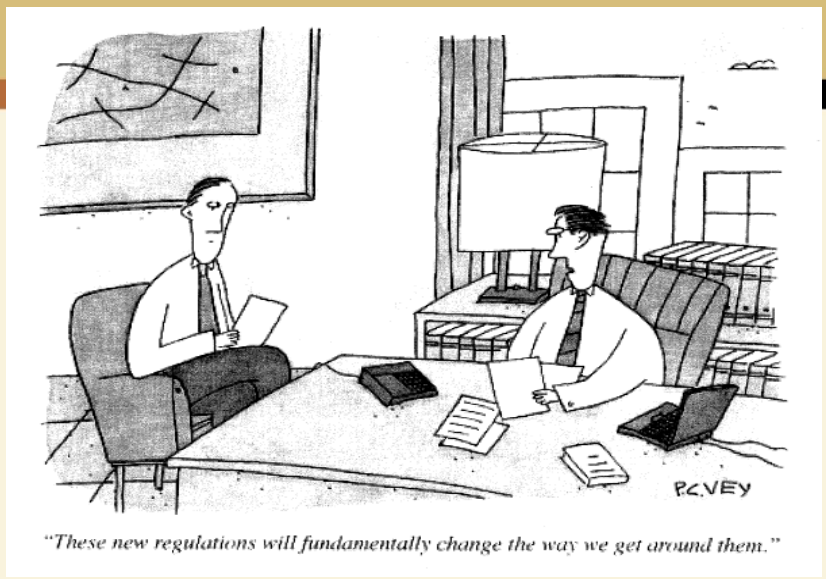

"These new regulations will fundamentally change the way we get around them."

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Not Just Another Fad

"Medicare's ACOs reduced spending by $466 million in 2015, according to fresh data from CMS."

$

On the downside: **nearly half** of participants didn't achieve any savings.

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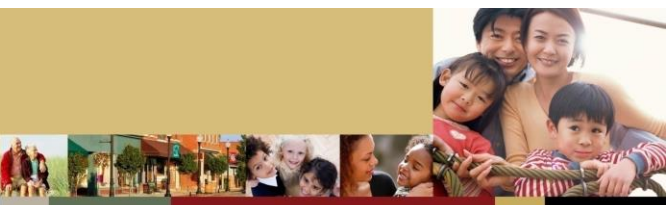
Questions?

SAMHSA

Substance Abuse and Mental Health Services Administration
SAMHSA
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)



Contact Information:

joep@thenationalcouncil.org